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ABSTRACT

This booklet was designed to help school personnel make good use of their opportunities for helping bereaved children directly as well as helping others in the classroom who may have concerns about death upon hearing of another child's loss. It provides necessary information for teachers on how children view death and the nature of bereavement responses, including what behavior changes are likely to occur, what anxieties a child may be experiencing, what responses may be helpful, and what to avoid. The difference between manifestations of grief that are considered within the normal range and those indicating the need for consultation with a mental health professional is explained. The first section of the booklet describes adults' reactions to bereavement. This section is included to provide school personnel with some insight into the home situation experienced by bereaved children. The next section looks at children's reactions, describing the behaviors associated with grieving children and some of their underlying thoughts, anxieties, and fantasies. Suggested ways of helping children and factors that make some children vulnerable are discussed. References are included; information on support groups is appended. (NB)

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helping bereaved children:

a booklet for school personnel

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INTRODUCTION

An estimated 5 percent of children—1.5 million—experience the death of one or both parents by the time they are 15 (Kliman 1979). The many children who lose siblings, close friends, or grandparents must also confront the reality of death and the painful and often frightening emotions associated with bereavement. Living with and helping these children as they cope with their losses can be difficult for adults who are also grieving. It is particularly difficult for adults who are not aware that children's responses to bereavement differ from adults' responses, and that how each child responds depends in part on age and stage of development. Important, too, is an understanding of the special vulnerability of children and the long-term negative outcomes that may result from this vulnerability.

Teachers and other school personnel occupy a unique position in relation to a bereaved child. They are with the child for many hours of the day—often a greater part of the child's waking day than is spent at home. Children may turn to their teachers for comfort, information, and help. Since, unlike members of the child's family, teachers are not themselves mourning the loss, they are able to objectively observe the child's behavioral responses to the death, to offer emotional support to the child, and to mobilize mutual support among the child's peers.

Parents, too, may turn to teachers for help. After a death in the family, parents may check to

find out how the child is doing socially and academically. They may also ask the teacher to help calm particular anxieties expressed by the child and to help modify grief-related behaviors.

If a child loses a parent, sibling, or other close person, school personnel may find that classroom peers are affected. For younger children, the death of a peer's parent may be their first close brush with death and their first real confrontation with the frightening reality that loved ones are vulnerable. And if a peer dies, children are confronted with their own vulnerability, as well as grief over their loss. School personnel can play an important role in helping children cope with this reality and in guiding children as they try to help a bereaved friend.

Children who watch television or read newspapers become aware of death in the world around them—sometimes quite dramatically, as in the Challenger space shuttle accident. A well-prepared teacher can help calm the fears and anxieties generated by such events.

This booklet is designed to help school personnel make good use of their opportunities for helping bereaved children directly as well as others in the classroom who may have concerns about death upon hearing of another child's loss. To be of help, teachers need to know how children view death and the nature of bereavement responses, including what behavior changes are likely to occur, what anxieties a child may be experiencing, what responses may be helpful, and what to avoid. The teacher needs to know the difference between manifestations of grief that are considered within the normal range and those indicating the need for consultation with a mental health professional. Teachers equipped with a sound understanding of bereavement in children

can provide invaluable help to parents who may not know what to expect of their children and may not be sure how to help.

The first section of this booklet describes adults' reactions to bereavement. It is included here so that school personnel will have some insight into the home situation experienced by bereaved children as a backdrop for discussing children's reactions. The second section turns to children. It first describes the behaviors associated with grieving children, then some of their underlying thoughts, anxieties, and fantasies. Suggested ways of helping children and factors that make some children specially vulnerable are discussed (for additional reading, see the complete Institute of Medicine report, Osterweis et al. 1984; Parkes and Weiss 1983; Raphael 1983).

ADULT REACTIONS TO BEREAVEMENT

Everyone assumes that sadness accompanies the death of a loved one, but the bereavement experience contains a much broader range of emotional reactions and behaviors. These can be upsetting if they are unanticipated, appear inappropriate, or are misunderstood. Knowledge about the various processes and outcomes associated with bereavement is likely to help avert some of the misunderstanding that can make the experience more difficult.

The first systematic study of bereavement was conducted by Erich Lindemann in 1944. He described uncomplicated grief as a syndrome with a predictable course and distinctive symptoms, including (1) somatic distress (physical symptoms), (2) preoccupation with the image of the deceased, (3) guilt, (4) hostility, (5) loss of usual patterns of conduct, and, in some people, (6) appearance of traits of the deceased (such as mannerisms or symptoms associated with a prior illness). Since that time, numerous clinicians and researchers have sought to corroborate these observations and to describe the grieving process in adults.

It is now generally agreed that:

The bereavement process is long, much longer than popular American notions would lead us to believe. Although, for many people, the worst is over within a year, evidence suggests that for some people the second year is more difficult than the first. For many people, the process may take several years.

The bereavement process does not necessarily progress in an orderly fashion, that is, people do not move systematically from one well-defined stage to another. Instead, they tend to move back and forth between what might be best described as overlapping and fluid phases.

Individual variation is substantial. People differ in how fast they recover and how they express their grief. Specific manifestations of grief depend on the personality and past experiences of the bereft person, cultural norms and expectations for behavior, the relationship with the deceased, the nature of the death, and the social milieu of the bereaved person.

Many emotions and behaviors that might be judged abnormal under other circumstances are common following bereavement, Nevertheless, some signs and symptoms may indicate serious problems that deserve the attention of a qualified mental health professional. However, the line between normal and abnormal (or pathological) is difficult to draw.

Anniversary reactions are common, even after the bereavement process is completed in the sense that one is again able to function and take pleasure in life. It is typical to experience new waves of grief around holidays, important family events, and the time of year when the death occurred. These anniversary reactions may become briefer as time goes by, but they may never entirely disappear.

The Phases of Bereavement Reactions

The most immediate response following death, regardless of whether the loss was anticipated, is shock, numbness, and a sense of disbelief. Because the reality of the death has not yet penetrated awareness, survivors may appear to be holding up well and to be quite accepting of the loss. This numbness usually turns to intense feelings of separation and pain in the days and weeks after the funeral. One psychiatrist describes this phase in the following way:

> The absence of the dead person is everywhere palpable. The home and familiar environs seem full of painful reminders. Grief breaks over the bereaved in waves of distress. There is intense yearning, pining, and longing for the one who has died. The bereaved feels empty inside, as though torn apart or as if the dead person has been torn out of his body (Raphael 1983).

During this phase, the bereaved frequently report illusions and misperceptions, such as seeing the dead person in the street and dreams in which the deceased is still alive. Eventually, these searching behaviors begin to decrease, but when the lost person fails to return, despair sets in. Depressed moods, difficulty in concentrating, anger at the deceased for dying, guilt about what might have been done to avoid the death, irritability, anxiety, restlessness, and extreme sadness are common during this time. Even the best-meant offers of comfort and support are often rejected because the grieving person is so focused on the deceased.

Dramatic and rapid swings from one feeling

state to another are also typical of the early aftermath of bereavement. Avoidance of reminders of the deceased may alternate with deliberate cultivation of memories for some time. Gradually the death begins to be accepted. However, survivors may be intellectually aware of the finality of the loss long before they emotionally accept the truth. Depression and emotional swings are characteristic of most people for at least several months and often for more than a year following bereavement. Eventually, the survivor is able to recall memories of the deceased without being overwhelmed by sadness or other emotions, and is ready to reinvest in the world.

Just as emotions may swing, so too the bereaved person may feel slowed down at one moment and restless and agitated the next. Crying and tearfulness are common following a recent loss. When emotional despair sets in, the bereaved may lose interest in the outside world and cease normal activities, including such relaxing pastimes as watching television or listening to music.

The functioning of all major body systems is likely to be altered during times of stress, including grief. Physiologic responses that begin as adaptive may sometimes become maladaptive and eventually deleterious to health if they continue too long or become too extreme, especially for those people who are vulnerable because of genetic predisposition or a past or current illness.

Quite apart from actual disease, recently bereaved people frequently report a host of physical complaints such as pain, gastrointestinal upset, sleep and appetite disturbances, lack of energy, and other symptoms that at another time might signal the presence of depression. Sometimes survivors report the same symptoms as the deceased and fear they have the same illness.

Health-threatening behaviors may intensify or appear for the first time. Smoking, drinking, and drug taking are common, especially among people who engaged in those behaviors to some extent before the loss. Changes in eating habits (especially over- and under-eating) are also common expressions of depression that can be harmful, particularly for diabetics and others whose diets need to be carefully controlled. Behaviors such as these can be indirect expressions of grief that may eventually compromise a person's health.

Finally, bereavement often precipitates changes in interpersonal relationships in the family and in one's broader social network. Bereft parents, for example, may be less emotionally available to their children because of their own grief. Children may experience this as a double loss. Family roles are likely to shift after the death of a member.

Outside the family, the bereaved not only see themselves differently in relation to others, but are also likely to be perceived in a new way by others. The nature of these interpersonal changes depends largely on the relationship that was lost and, sometimes, on the nature of the death. They are also powerfully influenced by the bereaved person's age and sociocultural context. The terms "widow" or "bereaved person" may evoke particular stereotypes or expectations, resulting in certain qualities being arbitrarily ascribed to the person. In addition, a middle-aged widow or widower may find social life greatly curtailed because people tend to socialize in couples. Parents who have lost their only child may no longer fit comfortably with other families. Thus, social isolation and loneliness are common, often long after the bereavement.

The End of the Bereavement Process

A healthy bereavement process can be expected to end with recovery of lost functions (including taking an interest in current life, hopefulness, and the capacity for enjoyment), adaptation to new roles and statuses, and completion of acute grieving. The length of time per se does not distinguish normal from abnormal grief, but rather the quality and quantity of reactions. A precise period of grieving cannot be specified.

Just as individuals vary in their reactions to grief, so too do they vary in outcome. What may signal recovery for one individual may signify continuing difficulty for another. For example, readiness to invest in new relationships does not always indicate completion of or recovery from grief. A seemingly quick remarriage or decision to have another child after one has died may reflect a sense of hope or strength in one case, whereas in another such actions may stem mainly from a wish to escape grief.

For some, bereavement provides an opportunity for personal growth that might not otherwise have occurred. Widows who had very traditional marriages, for example, may be forced to take on new roles and acquire new skills following the death of a husband. Being able to rise to these challenges successfully may leave a widow with a greater sense of competence and independence than when she was married (Silverman 1982).

Those Who May Be at Risk Following Bereavement

Because of their particular life situations or personal characteristics, some people have been

found to be more vulnerable than others following the death of someone close. In general, children are more vulnerable than adults. The gender and age of bereaved individuals, the nature of their relationships with the deceased, the nature of the death, and certain behaviors and social situations that appear soon after the death may affect how well the bereaved person ultimately fares.

Following the death of a spouse, widowers are more likely to die than are men the same age who have not lost their wives. This increased risk for premature death, which is characteristic for men up to age 75, seems to persist for many years unless the men remarry. Among widowers who remarry, the likelihood of dying prematurely is no greater than for non-widowed married men the same age. It is not clear, however, whether marriage itself protects against ill health in bereaved men or whether their good health permits remarriage. Increased risk of premature death in the first year does not seem to characterize women who have lost their husbands, although there is some evidence for higher death rates in the second year following bereavement. Widows are much less likely than men to remarry because fewer single men are available (Helsing et al. 1981, 1982; Clayton 1982). This may heighten widows' vulnerability to some other stresses, including social isolation and financial problems that may require major alterations in lifestyle.

The nature of the particular relationship may also influence the course of bereavement reactions. The literature on conjugal bereavement is replete with data indicating that individuals who had highly ambivalent relationships with their spouses fare worse following bereavement than people whose relationships were less conflicted (Parkes and Weiss

1983). It appears that ambivalence—the simultaneous presence of positive and negative feelings—heightens feelings of guilt following the death of a close person and complicates the emotional grieving process. Also, excessively dependent people, for example, spouses who cannot (or fears they cannot) function independently, do poorly following bereavement (Parkes and Weiss 1983).

In terms of the nature of the death, it has frequently been hypothesized that sudden death is more traumatic for survivors and leads to poorer outcomes than deaths that are anticipated. While common wisdom holds that time to say goodbye and to express love will facilitate grieving by lessening later feelings of anger and guilt, the moment of death is always a shock no matter how much warning has been given. And although some warning about an impending death may facilitate grieving, a very lengthy terminal illness produces its own stresses and strains that may complicate the grieving process. During a prolonged illness, families are more likely to witness suffering and sometimes dramatic personality changes in the patient that may heighten feelings of anger toward health professionals and guilt for not having done more (even if there was nothing more that could have been done) to ease the dying process.

One type of death that clearly leaves survivors more vulnerable to long-term difficulties is suicide. Typically, more psychological distress is experienced by family members following death by suicide than death from natural causes. Heightened anger directed at the deceased and guilt for not having been able to prevent the death, as well as true clinical depression, are more likely to occur and persist. This group of bereaved, especially children whose parent(s) committed suicide, are

themselves more vulnerable to suicide (MacMahon and Pugh 1965; Birchnell 1970; Lloyd 1980).

In addition to the risk factors that are present before bereavement or are related to the nature of the death, some elements of the early bereavement process itself can also affect ultimate outcomes. The stress of bereavement appears both to exacerbate preexisting physical and mental disorders and to precipitate or exacerbate certain behaviors that are dangerous to health. It has generally been found that among people who already use alcohol, drugs, or cigarettes, consumption of these substances increases, while other people may begin using these substances for the first time during a relative's terminal illness or following bereavement. The relative risk of death from cirrhosis increases among widows, indicative of heavier drinking following loss. Among widowers, there is an increase in the relative risk of death from accidents, cardiovascular disease, and some infectious diseases. Individual symptoms occurring during the early bereavement period that may also predict poor outcomes include suicidal preoccupation (particularly after the first month) and morbid (excessive) guilt.

Bereavement researchers have devoted more effort to studying those factors that place people at risk for poor outcomes than to identifying factors that may be especially helpful to the bereavement process. However, considerable evidence has accrued showing that social support has a positive effect on general health status and may serve as a protective factor to buffer or modify the impact of adversity on both the mental and the physical health of the individual. Conversely, perceived lack of social support is one of the most common risk factors cited in the bereavement literature. The per-

ception by the recently bereaved that no one is around to talk to or lean on appears to be a reliable predictor of poor outcomes (Parkes and Weiss 1983).

It is important to reiterate that although bereavement is stressful for virtually everyone, most people are able to move through the process without specialized professional help. Some people, however, are so predictably vulnerable that they should be monitored closely. These include adults with a history of depression or alcoholism, adults and children who are bereaved because of suicide, and those who have sustained multiple losses within a short time. Certain symptoms and behavior following bereavement should alert observers to the need for help from a mental health professional. These include persistent suicidal thoughts, fantasies beyond the first few weeks, and a sense of being stuck in one's grief or of being unable to grieve.

CHILDREN AND BEREAVEMENT

Given the profound effects of bereavement on adults, it is understandable that children have an even more difficult time because they are simply not as well equipped to cope. In addition to the upset caused by the fact of the death, children may be concerned and worried about the obvious sadness and the emotional swings and behavior changes of the adults around them, and may have to adjust to altered styles of interaction and living patterns as well.

Probably the single most important fact to keep in mind when dealing with bereaved children is that children are children—they do not think or behave like adults. Considerable misunderstanding, confusion, and hurt feelings can be avoided by not expecting adult behavior. Although how they respond to loss depends largely on their age and stage of development, children show substantial individual variation and a wide range of reactions.

After learning of a death, young children may seem not to focus on the event for long. They often resume playing as if nothing untoward has happened. Within a few weeks they may express a desire for a new parent or sibling to replace the one who died. It is common for young children to make seemingly glib statements and ask the same questions repeatedly about the death. They may express feelings in ways that are surprising and unnerving to adults, exhibiting aggressive and hostile behavior or a seeming lack of concern rather than sadness.

Young children respond this way not because

they are uncaring, but because losses are so painful and frightening that many young children—able to endure strong emotions for only brief periods—alternatively approach and avoid their feelings so as not to be overwhelmed. Because these emotions may be expressed as angry outbursts or misbehavior, they may not be recognized as grief-related. Furthermore, because their need to be cared for and nurtured is intense and immediate, young children typically move from grief reactions to a prompt search for and acceptance of replacement persons. Unlike adults who can sustain a year or more of intense grieving, children are likely to manifest grief-related emotions and behavior intermittently for many years after the loss has occurred. Various powerful reactions to the loss normally will be revived, reviewed, and worked though repeatedly at successive levels of development. Even adolescents, whose reactions are more similar to those of bereaved adults, are likely to have difficulty expressing their emotions directly for fear of appearing to be different from their peers.

It is important for teachers to be aware that children's immediate responses are not necessarily good predictors of what they will demonstrate later. That a child seems to make a good, quick recovery does not ensure the absence of serious emotional problems. An Israeli study (Elizur and Kaffman 1982) showed that the children with the most severe immediate reactions to loss developed the most prolonged and pathologic type of grieving, but also that some who seemed stable in the early months deteriorated in the second to fourth years. Teachers can expect to see some bereaved children functioning poorly in school for a prolonged period. Such children are likely to have academic problems, be less interested in school activities, and be more

likely to drop out of school. Among adolescent boys, delinquency has sometimes been linked to bereavement, and some observers report that girls turn to sexual relationships for comfort and reassurance (Raphael 1983). Although not all bereaved children exhibit these behaviors (and these behaviors are not unique to those who have experienced a loss), these symptoms of emotional difficulty may be the result of bereavement and may signal a need for special help.

Children's Thoughts and Emotions

As they work through the process of bereavement, children's behavior does not always offer direct clues to their thoughts and feelings. Children's ability to work through bereavement and complete their mourning depends in part on their ability to distinguish between death and temporary separations. Before the age of 6 or 7, children to not generally grasp the notion that death is irreversible. After that age, most children understand the finality of death but may not regard it as inevitable, universal, or of immediate relevance to them. By age 11, nearly all children understand that death is inevitable and represents the end of the life cycle. Only at this point does the child begin to conceptualize the future in terms of potential losses (Bluebond-Langer 1978; Koocher 1973). It should be noted that for children who are intellectually precocious or retarded these ages will vary. In addition, children with previous bereavement experience and those who are facing their own deaths are likely to have a greater understanding at an earlier age.

In the past, some experts asserted that because very young children do not understand death and

lack the capacity to mourn in a manner analogous to adults, they are unable to complete the process and are likely to have problems for the rest of their lives. A substantial body of research literature now demonstrates that even very young children are able to grieve and make use of family supports to cope with loss. The chief difference between bereft children and adults is in the way they manifest their grief and in the children's need to rework and reintegrate understanding of the loss as they develop and are able to comprehend the event at new levels. Thus, although bereavement may render young children vulnerable, long-term problems are neither as frequent nor as inevitable as was once thought. How a young child fares after sustaining a major loss will depend in large part on the adequacy and availability of supportive adults.

While teenagers are thought to have the maturity to experience sustained pain and complete their mourning, they have a special vulnerability because they are simultaneously experiencing the normal developmental turbulence of adolescence. This already confusing time in life can only be made more disturbing if the adolescent must deal with the death of a parent, sibling, or peer through illness, or the shock of a violent death by suicide or accident. The increasing frequency and epidemic nature of teenage suicide—one teenage suicide sometimes being followed by others in the community—suggests that attention be directed toward this vulnerable group as they grapple with their bereavement.

Not all emotions associated with childhood bereavement are related to age. As with adults, guilt is a fairly universal feeling—that the child in some way caused the death. Children occasionally wish that their parents or siblings were dead and

sometimes articulate this angry feeling. If one of them does die, young children, being literal minded, might well believe themselves to be the agent. Loss of a parent can also cause other changes in a child's self-image (Kliman 1980). Children who interpret a parent's death as a kind of desertion believe this would not have happened had they been more lovable.

Children may identify with the dead person. Over-identification, however, can lead to fears that they themselves are sick and dying, to an attempt to fulfill the deceased's role of "man (or woman) of the house," or "good child," or to take on other such characteristics. Other children ward off the pain of loss by fantasizing that the parent is alive and will return. Both adults and children tend to idealize the dead person. Thus, in some children's fantasies, the dead parent is perfect while the surviving one is bad, or the dead sibling is perfect and the surviving youngster is bad.

These fantasies and undermining of self-esteem translate into some basic questions and anxieties. Three questions, whether articulated or not, commonly occur to children who have lost a parent: Did I cause this to happen? Will it happen to me? Who will take care of me now? They worry that the dead person will come back and seek revenge, that others will die too, or that their basic needs will not be taken care of (Bowlby 1980). Their sense of the world as a safe, predictable place may be traumatically affected by their loss.

How to Help Bereaved Children

Teachers who see a grieving child exhibiting sad, difficult, and often seemingly irrational or unfeeling

behavior need to understand what is going on in the child's mind—the thoughts, emotions, and fantasies. Because they are with the children every day, teachers are able to observe the course of grieving and may witness behaviors that indicate need for some discussion, explanation, or reassurance. A teacher who is not personally affected by the death may be better able to meet these needs than a grieving parent. Grief can cause parents to be impatient and irritable just when their children need them most. Chaos and disorganization at home often compound the impact of living with a sad and anxious parent. Living arrangements may be disrupted, the family may move, and discipline may be inconsistent, with a previously permissive parent becoming strict or vice versa. By contrast, school may seem a secure, constant environment and the teacher a needed, unchanging, stable anchor in a confused time.

School personnel can also respond to a fundamental need of bereaved children for an adult to reiterate that a death has occurred, that it is final, and that it is all right to express feelings. School personnel may also be in a position to provide answers to the questions that children ask: What will happen to me now? Did I cause this to happen? Will I die too? and to make sure that the answers are understood because unless they are, feelings of fear and anger are likely to occur.

Well-meaning adults who tell children directly or indirectly that they should fill the gap left by the death of a parent or sibling (e.g., be the man or woman of the house, look after the bereft parent, be the model child) can cause the child to over-identify with the dead parent or feel a heavy and inappropriate burden of responsibility. Idealization of a dead sibling can make the surviving children feel

unloved and guilty about surviving. Excessive dependence by a parent on surviving children can generate anger and make recovery more difficult.

While school personnel cannot forestall inappropriate parental actions, they are well situated to conduct useful education about death. Many authors agree on the value of teaching young children about death before it enters their lives in an intimate way. Children are naturally curious about death, and their questions provide adults with opportunities to ensure that they get accurate information. Many children's books and common school topics (such as the pyramids of ancient Egypt) provide good vehicles for generating discussions about death.

School personnel should be aware that a family's religious and cultural beliefs determine what is appropriate for a child to hear about death. If possible, it is helpful to work closely with the bereaved child's family. In general, use of religious explanations is controversial. Some think that telling children that a dead person is in heaven watching them can upset young children, who tend to be literal-minded. Similarly, remarks about the dead person having been specially chosen by God may be interpreted to mean, "I better not be good or God will take me, too."

There is, however, little disagreement that it is helpful to tell the truth in terms appropriate to a child's developmental stage. An adult's silence is more likely to increase fears and fantasies than to spare children from sorrow. Like adults, children need information. Answer their questions. Tell them that a dead person will not be alive again; that a dead person no longer suffers; that the child will not die; that the surviving youngster was not responsible for the death; that he or she will not be abandoned. Help the children differentiate reality from fantasy,

and help them speak of their fears. This approach—the confirmation of the irrevocable nature of death, the end of suffering, the acceptance of sadness and of expressions of grief, and the assurance that one death does not mean that the same thing must happen to another beloved person—can also be used by teachers when talking to the peers of a bereaved child. When a child learns that a friend has lost a close relative, he or she may become alarmed—will my mother die too?—and uncertain about how to behave toward the bereaved friend. Open classroom discussion during which children can express their anxieties and fears, hear that others, too, are confused, and receive reassurance and guidance from their teacher, can provide needed help.

Classroom discussion can also be used to help children and adolescents through the confusion and grief caused by the death of a peer—whether by illness, suicide, or accident. Class expressions of sympathy such as visiting the parents or sending flowers can help both the bereaved parents and the children. School personnel may benefit from advice from a mental health professional on how to help bereaved children, especially following a suicide or other violent death, and it may also be useful to invite an experienced mental health professional to meet with the children for one or more group discussions.

An immediate problem about which parents of young children may consult school personnel is whether they should attend the funeral. Some fear that children will be upset or frightened. Most experts recommend that children be allowed, but not forced, to participate. As is true for adults, participation in mourning rituals can help children mark and understand the finality of death, can underscore the child's role as an important family

member, and can help dispel fantasies—but only if the funeral is approached without excessive anxiety.

Preparing the child for the funeral service can help. The child can be told what the room will look like and what will happen. Children should be told in advance if the casket is to remain open, and may be given the opportunity to look at or touch the deceased one last time if they want. Observers agree that it is unwise to insist, however, that a child touch a corpse. The child should be with an adult who can accompany him out of the room if the service becomes too upsetting. Telling a child that a lot of people may be crying because of their sadness may be useful preparation as well. A funeral may also be portrayed positively as a way for people to help comfort each other after a loss.

Childhood bereavement can have long-term consequences. School personnel should not be surprised to see recurrences of grief on anniversaries of the death, birthdays and holidays, and developmentally significant events such as first communion and graduation. Events that mark the passage to a new phase of life may also trigger renewed grief in the adults in the family. At these times, the most helpful intervention is supportive reassurance that the sadness is normal.

Vulnerable Children and Signs That Professional Help Is Needed

Not all responses to grief are normal and healthy. Reactions such as regression, denial, inability to function, and emotional disturbance are normal in childhood grieving for awhile following bereavement. However, reactions that persist or become extreme may indicate significant problems.

Thus, for children and adults, the intensity and duration often differentiate the normal from the pathological. Disturbed behaviors have been grouped into three categories—suppressed or inhibited responses, distorted grief (e.g., extreme guilt or anger), and chronic grief (Raphael 1983). Persistent anxieties, hope of reunion, a desire to die, persistent self-blame and guilt, continued overactivity with aggressive and destructive outbursts, compulsive care-giving and self-reliance, over-identification with the deceased, inability or unwillingness to speak of the deceased person, exaggerated clinging to the surviving parent, and extreme idealization or degrading of the dead parent or sibling indicate a need for help. Apparent absence of grief, strong resistance to forming new attachments, complete absorption in daydreaming to the point of dysfunction, and the onset of antisocial acts such as stealing are other red flags that should signal a referral to a specialized mental health professional for consultation.

Some specific factors appear to be associated with greater susceptibility to adverse outcomes, including depression in adult life. Some of these have to do with the age at which the loss occurred and some with whether the parent of the same or opposite sex died. The evidence on which factors, or clusters of factors, place a person at risk is not always consistent. However, for those concerned with the well-being of bereaved children, the important issue is not so much what type of adverse outcome is likely to occur but rather which children are at risk for an adverse outcome and should be observed for signs that help is needed.

A review of the clinical and research data suggests that the following factors increase the risk of

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long-term negative outcomes following the death of a parent or sibling:

- Loss occurs when the child is under 5 years of age or during early adolescence
- Loss of mother for girls under 11 and loss of father for adolescent boys
- Preexisting emotional difficulties
- Preexisting conflict between the child and the deceased
- A surviving parent who becomes excessively dependent on the child
- Lack of adequate family or community supports, or a parent who cannot use support systems
- Unstable, disrupted environments including numerous caretakers and broken routines
- Parent who marries someone with whom the child has a bad relationship
- Sudden or violent death (including suicide or murder)

CONCLUSION

It is important for those who care for bereaved children to bear in mind that children are not adults—their responses to loss differ in many ways from those of adults and are largely determined by the age and developmental stage of the child. The special vulnerability of children to long-term consequences is partly due to developmental immaturity, as is some of the apparently unfeeling or difficult-to-understand behavior that may be observed as children learn to live with their loss. Such anxieties as the fear that they or the remaining parent will also die can be reduced by caring, responsive adults. But, while well-informed and responsive adults can play a large role in helping a child toward a satisfactory mastery of grief, it must be remembered that it will be a long process. Evidence of emotional upset may continue to appear for many years. Each type of death is associated with particular anxieties; the kinds and sources of anxiety will vary with the child and the situation.

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APPENDIX

The following list of voluntary organizations and mutual support groups may be helpful in identifying resources in your community for the bereaved and for those who are anticipating death. Although numerous support groups are available to assist dying children, relatively few serve bereaved children. Thus, this list may be more useful for parents who ask for assistance. Clergy, funeral directors, health professionals, and health care organizations are generally knowledgeable about resources for the bereaved.

POSTBEREAVEMENT MUTUAL SUPPORT GROUPS

For Widowed Persons

THEOS (They Help Each Other Spiritually)
Office Building, Suite 306
Penns Hill Mall
Pittsburgh, PA 15235

For young and middle-aged widowed persons; each chapter has a chaplain; 100 chapters nationwide.

Widow-to-Widow Programs

Hundreds of local mutual help groups and networks sponsored by churches/synagogues, YM/ YWCAs, community mental health centers, family service associations, mental health

associations, funeral directors associations, and freestanding community groups.

Widowed Person Service Directory lists about 400 groups nationwide. New Jersey Self-Help Clearinghouse lists 42 in State of New Jersey alone.

Widowed Persons Service
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20049

Peer support and visitation to widowed persons; 135 groups nationwide; AARP-WPS provides consultation and training for leaders of new local groups.

For Survivors of Suicide

Seasons: Suicide Bereavement, Inc.
4777 Maniloa Drive
Salt Lake City, UT 84117

For families and individuals (including therapists, police, and work colleagues) who have lost a significant other by suicide; co-facilitators involved in support group discussions—a survivor and a professional; national organization.

Survivors of Suicide (S.O.S.)
c/o Fr. Arnaldo Pagrazzi, Chaplain
St. Joseph's Hospital
5000 W. Chambers Street
Milwaukee, WI 53210

For families and friends of suicide victims.

For Parents

The Compassionate Friends
P.O. Box 1347
Oak Brook, IL 60521

For bereaved parents; 325 groups nationwide.

Families of Homicide Victims
2 Lafayette Street
New York, Ny 10007

For parents of homicide victims.

Mothers Against Drunk Drivers (MADD)
5330 Primrose, Suite 146
Fair Oaks, CA 45628

Open to all citizens; many are survivors of drunk driver caused crashes; many are relatives and friends of victims; national organization.

National Foundation for Sudden Infant Death (SIDS)
1501 Broadway
New York, NY 10036

For parents who have lost a child to crib death.

National Sudden Infant Death Syndrome Foundation
8240 Professional Place
2 Metro Plaza, Suite 205
Landover, MD 20785

For parents who have lost a child to crib death; national organization.

Parents of Murdered Children
1739 Bella Vista
Cincinnati, OH 45237

For parents of murdered children; recently established a new category of group—Survivors, for other relatives such as sibling, grandparent, and adult child of a murdered parent. 40 chapters nationwide plus contact persons.

VOLUNTARY ASSOCIATIONS (WITH SUPPORT GROUPS) AND MUTUAL HELP GROUPS FOR PATIENTS AND FAMILIES WITH LIFE-THREATENING ILLNESSES

Alzheimer's Disease and Related
Disorders Association
2501 West 84th
Bloomington, MN 55431

For caregivers of Alzheimer's patients.

American Cancer Association
777 Third Avenue
New York, NY 10017

- Man-to-Man: Peer visitation programs by partners of women who have mastectomies
- Reach to Recovery: Peer counseling by women who have undergone mastectomy
- Lost Chord, Anamilio, and New Voice Clubs: 260 clubs nationwide are members of International Association of Laryngectomies
- I Can Cope: A support group for cancer patients and their families

American Lupus Society
23751 Madison Street
Torrance, CA 90505

For patients and families; 100 chapters nationwide.

American Parkinson's Disease Association
116 John Street
New York, NY 10038

For Parkinson patients, their families and friends.

Amyotrophic Lateral Sclerosis Society of America
15300 Ventura Boulevard, Suite 315
P.O. Box 5951
Sherman Oaks, CA 91403

For patients and their families.

Association of Heart Patients
P.O. Box 54305
Atlanta, GA 30308

Candlelighters Association
2025 I Street, N.W.
Washington, DC 20006

For parents of children with cancer; 155 chapters nationwide. Newsletters of other publications for parents and adolescents as well as support groups.

Center for Attitudinal Healing
10 Main Street
Tiburon, CA 94920

Mutual help pen pal/phone pal program for children, parents, or other adults with life-threatening illness.

CHUMS
(Cancer Hopefuls United for Mutual Support)
3310 Rochambeau Avenue
New York, NY 10467

For cancer patients/survivors and their families and friends.

Committee to Combat Huntington's Disease, Inc.
250 W. 57th Street
New York, NY 10107

For patients and affected families; 29 chapters nationwide plus branches and area representatives in 44 states.

Coronary Clubs, Inc.
3659 Green Road
Cleveland, OH 44122

C.U.R.E. Childhood Cancer Association
315 Marion Street
Rochester, NY 14610

For children and families.

Cystic Fibrosis Foundation
6000 Executive Boulevard, Suite 309
Rockville, MD 20852

For parents of children with cystic fibrosis; national organization.

Gillain-Barre Support Groups
1305 Wyngate Road
Wynnewood, PA 19096

For victims of GB Syndrome.

The Lupus Foundation
11673 Holly Springs Drive
St. Louis, MO 63141

For patients and families; 70 chapters nationwide.

Make Today Count
P.O. Box 303
Burlington, IA 52601

For persons facing a life-threatening illness and their relatives and friends; 300 chapters nationwide.

Myasthenia Gravis Foundation
15 East 26th Street
New York, NY 10010

For myasthenics, relatives, and friends; 51 chapters nationwide.

National AIDS Network
729 8th Street, S.E.
Suite 300
Washington, DC 20003

Information clearinghouse for AIDS patients, friends, and families regarding resources in local communities across the country.

National Association of Patients on
Hemodialysis and Transplantation
156 Williams Street
New York, NY 10038

For patients, their families and friends; 33 chapters nationwide.

National Head Injury Foundation
18A Vernon Street
Framingham, MA 01701

For families of head injured; 28 chapters nationwide.

National Hospice Organization
1901 North Fort Myer Drive
Arlington, VA 22209

For terminally ill patients and their families; more than 1,000 hospice programs nationwide.

National Multiple Sclerosis Society
205 East 42nd Street
New York, NY 10017

For patients and their families; 124 chapters nationwide.

National Tay-Sachs Parent Network
122 E. 42nd Street
New York, NY 10017

For parents of children with Tay-Sachs.

Parents of Prematures
13613 NE 26th Place
Bellevue, WA 98005

For parents who experience birth and hospitalization of premature or critically ill babies.

Phoenix Society
11 Rusthill Road
Levittown, PA 19056

Recovered burn victims work with severely burned people and their families; national organization.

SHARE (Self-Help Action and Rap Experience)
34 Gramercy Park
New York, NY 10003

For women who have had a mastectomy.

SKIP (Sick Kids Need Involved People)
216 Newport Drive
Severna Park, MD 21146

Helping families of children with various levels of medical instability care for their child at home; new organization.

Spina Bifida Association of America
343 South Dearborn, Suite 319
Chicago, IL 60604

100 chapters nationwide.

Stroke Clubs
7320 Greenville Avenue
Dallas, TX 75321

For those who have had strokes and their families; 312 clubs nationwide.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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